Practice Manual for the Rehabilitation Option for Mental Health Services for Adults, Children and their Families

I. PURPOSE

The purpose of this manual is to provide information and guidance for decision making and implementation of psychosocial rehabilitative services. In addition, it includes state policies and procedures developed to ensure an optimal amount of statewide uniformity. This manual is based on federal (HCFA) requirements and Department of Health and Welfare rules for the provision of the Medicaid Rehabilitative Services Option for Mental Health Services. It is expressly written for RMHA staff and Medicaid provider/agencies.

The answer to every question or every situation will **not** be found in this manual. There will also be changes in the interpretation of Department rules as time and practice enhance our knowledge about how to improve services. In this manual you will find information on the background, principles/values and basic "how-tos." You will also find references to other helpful documents and standardized forms including the Department Rules Governing Rehabilitative Services and their Interpretive Guidelines, Medicaid Provider Application, Supplemental Service Agreement, and other relevant Department rules and procedures; e.g., case transfers. You are encouraged to use this information and apply it to specific situations.

II. MISSION, VALUES, CRITICAL SUCCESS FACTORS, and VISION

The **mission** of the Department of Health and Welfare is to promote and protect the health, safety, and self-reliance of Idahoans.

The Department's **values** are: self reliance; personal, family and community responsibility; partnership and participation; accountability; employee contribution; response; and communication.

The Department's Strategic Plan identifies **critical success factors** that must exist if the Department is to achieve its long term goals. The following critical success factors from the DHW Strategic plan equally apply to the success of the Department's vision for public mental health services:

Understanding and acceptance of the Strategic Plan. The Department will achieve its

goals when employees can understand and relate their work activities to the Department's mission, vision and strategic direction;

A single business enterprise, where organizational and information "silos" are removed, and divisions, regions, and institutions within the Department of Health and Welfare function as a single business enterprise, concentrating upon that core of services for which we are held legally accountable and for which we are authorized funding and staff to perform. This will require the Department to:
(1) Improve internal communications, working relationships, and information sharing between organizational units;
(2)Improve information sharing between automated systems; and
(3)Conduct a continuous assessment of the need for other services which are not "core" for their potential linkage to other public and private entities;

Effective collaboration with communities in the planning, delivery, and oversight of key services. The Department must improve linkages with communities, strengthen its abilities to stimulate community interest and activity, collaborate with other agencies, and establish mechanisms for obtaining routine feedback from taxpayers, consumers, staff, and service providers;

Public awareness. The public has a right to know how it is affected by the Department's programs. The Department must be diligent in communicating its progress toward attaining its mission and achieving its goals;

Focus on self-reliance, not dependency, in the delivery of services. To bring about self-reliance by encouraging acceptance of responsibility, accountability, and independence. We must understand that persons utilizing our services do so for differing reasons. However, they all have strengths and abilities that can help them use services wisely. Our role is to help them focus on those strengths and abilities in a manner that fosters self-reliance;

Focus on organizational performance. The Department is a learning organization that constantly seeks to enhance its ability to create its future. To achieve this, the Department encourages the use of creative and imaginative decision making while focusing on accountability and effective judgement, developing strategies to manage the impact of rapid change on the Department and its employees, and retaining flexibility to change organization structure, workflow, and work processes as necessary to reach its goals;

Access to information. Basic management information must be available to support program planning, implementation, monitoring, and evaluation. The Department should be able to clearly identify desired outcomes, identify ways to measure success in reaching outcomes, and develop mechanisms for collecting, analyzing and reporting outcomes and

performance data;

Productive, contributing employees who are empowered to carry out their responsibilities, and provided with the tools they need to operate effectively. Employee productivity and satisfaction must be promoted through continual quality improvement, internal communication, training opportunities, management strategies, and through staff who are able to work effectively with diverse cultures; and

Quality Contracted Services. The Department must ensure quality service providers through improved Requests for Proposals (RFP), contracting, and contract monitoring processes.

These values and critical success factors are embodied in the **vision** for implementation of the Medicaid Rehabilitative Services Option:

> **To achieve an optimal mental health system of community-based and consumer-guided services which is an integrated and coordinated blend of public and private services.**

Rehabilitative Principles guide planning and practice. Rehabilitative Services should:

- Focus on strengths and empower consumers;
- Be consumer centered and provide maximum choice;
- Be assertive, responsive, respectful, and accountable;
- Be flexible and tailored to individual needs and desires;
- Incorporate natural supports;
- Be coordinated and seamless;
- Be cost effective and efficient; and
- Be racially and culturally appropriate as well as have sufficient culturally competent staff at all levels.

III. MANAGED SERVICE DELIVERY AND MEDICAID

Managed service delivery is a strategy for making sure individuals covered by a specific insurance plan receive "the right services in the right amount, at the right time, while containing costs." Under managed service delivery, provider agencies are accountable for the outcomes of their services. To assure maximum use of public resources, Medicaid is moving from a fee-for-service to a managed service delivery structure.

Medicaid is a public health care insurance program for eligible adults and children funded by

state and federal dollars. Eligibility is determined by income and/or presence of a disability. Medicaid covers **"medically necessary**" services including a variety of mental health services.

According to Idaho Rules Governing Medical Assistance, a service is "medically necessary" if:

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction; and

b. There is no other equally effective course of treatment available or suitable for the client requesting the service, which is more conservative or substantially less costly.

Public mental health services in Idaho are delivered under several Medicaid options: Early Periodic Screening, Diagnosis and Treatment (EPSDT), Targeted Case Management, Rehabilitative Services and Clinic Options. The Rehabilitation Option was added in 1994. It is a way to focus relevant services on the most severely mentally ill and move services out of mental health clinics into communities. The Rehabilitation Option is designed to support community-based services for persons with serious mental illness.

The Rehabilitative Services Option provides the state a unique opportunity for local management of mental health services with the following goal: **To ensure individuals with the most need receive necessary services and experience positive outcomes**. Local management of services is accomplished through the Regional Mental Health Authority (RMHA) in partnership with private provider agencies who can offer relevant services to persons with a severe mental illness.

Traditional clinical services, such as those provided under the Clinic Option, are office-based and focus on reducing symptoms of an underlying illness. Rehabilitative Services focus on treating the underlying illness as well as its effects including impairment in life functioning in school, home, work, community, peers, and family. Rehabilitative Services are more intensive and cover a greater range of services which are provided in more natural and diverse locations. Currently, under other Medicaid options such as the Clinic Option, the private provider agency works directly with Medicaid on a fee-for-service basis. Under these other (non-Rehabilitative) options, the consumer seeks out a provider who will accept an Idaho Medicaid card. The provider determines the plan, provides the service, bills Medicaid, and receives reimbursement.

Since implementation of the Rehabilitative Option, the Department has been in the midst of a role change - from the role of provider of direct services to the role of manager of publicly funded mental health services. This makes it imperative that private provider agencies develop capacity and expertise to serve more severely mentally ill consumers than they have been able to serve in the past. Under this managed system of care, DHW's responsibilities include training, service authorization, technical advising, monitoring, and evaluation.

IV. REGIONAL MENTAL HEALTH AUTHORITY (RMHA)

In 1996, Governor Batt and the Legislature stated their desire to expand the capacity of community mental health services without expanding state government. To accomplish this, a partnership between the Department and the private sector was established to develop the private sector's expertise and motivation to serve persons with severe mental illness or serious emotional disturbance. The Regional Mental Health Authority (RMHA) was created to support this partnership development.

The RMHA is the regional director or his or her designees; i.e., the Adult Mental Health Program Manager and the Family and Children's Services Program Manager. The role of the RMHA is to locally administer and manage Medicaid Rehabilitation Option benefits.

Under the Rehabilitation Option, the RMHA establishes agreements with private provider agencies who qualify to be Medicaid providers for the designated target populations. The RMHA screens potential Rehabilitative Option consumers, engages the consumer in assessing their service needs and determining their goals, preauthorizes the amount and kind of services necessary to accomplish the goals, and refers consumers to a choice of appropriate providers for development and accomplishment of the Task Plan.

Basically, the RMHA uses four strategies to manage service delivery:

1. **Identification of the Target Population;**
2. **Preauthorization of Services;**
3. **Working with Consumers and Provider Agencies; and**
4. **Managing Service Delivery for Quality & Outcomes.**

For successful implementation, each strategy requires both clinical and administrative RMHA roles and responsibilities. Clinical roles and responsibilities generally involve direct consumer contact; e.g., assessment, diagnosis, and planning, and limited service delivery. Administrative roles and responsibilities generally involve direct activities with providers to support the service delivery system; e.g., negotiating provider agreements and monitoring quality.

RMHA CLINICAL ROLES AND RESPONSIBILITIES

1. Identification of the Target Population

RMHA staff is responsible for screening activities and completing a Comprehensive Assessment to determine if applicants meet target population criteria. Under the Rehabilitative Option, the eligibility criteria for adults are the presence of a severe and persistent mental illness that significantly impairs functioning and impacts their ability to live independently in the community. For children, these criteria are a severe emotional disturbance which significantly impairs their ability to function at home, at school, with

peers and in the community.

Individuals, both adults and children, who meet the target population definition but are ineligible for Medicaid should receive the same service planning and services as do Medicaid recipients. Most often these services are provided via individual contracts with private providers. Medicaid prohibits discrimination in the delivery of services regardless of Medicaid eligibility and/or ability to pay.

Medicaid/target	non-Medicaid/target	Medicaid/non target	non-Medicaid/non target
Appropriate for Rehabilitative services	Appropriate for Rehabilitative services	Refer for non-Rehabilitative Medicaid services in the community	Referral to non-Medicaid community services

2. Preauthorization of Services

Using information gathered from the Comprehensive Assessment, RMHA staff and the consumer identify rehabilitative goals and objectives. These goals and objectives form the basis of the Service Plan. The Service Plan identifies the goal(s), areas of need/issues, the objectives, and the total number of hours estimated to achieve all objectives, based on the ability of the consumer to effectively use services. In some instances, the Service Plan may be more prescriptive and specify how the total hours are to be allocated among the services.

The consumer and selected provider(s) then develop the Task Plan. The Task Plan describes the specific tasks that will lead to accomplishment of the objectives. The Task Plan also describes how the preauthorized hours are proposed to be allocated among specific service(s). For example: three hours of group psychosocial rehabilitative services (a service) to teach symptom management (a task) or to develop pro-social interaction with peers (a task); and/or three hours of individual psychosocial rehabilitation services (a service) to teach budgeting skills (a task).

The Task Plan must be preauthorized by the RMHA before the provider agency can begin billing for services. Tasks may need to be added or revised as progress is or is not made. When task changes are needed, the provider will provide the RMHA with a copy of the Task Plan amendments. The provider will be notified promptly if the amendments are not acceptable. The Service and Task Plans are revised when necessary, but not less than annually**.**

The primary concerns of the RMHA are that the consumer meets his or her objectives and achieves and maintains positive outcomes. Toward this end, the provider and consumer are responsible for achieving the stated objectives within the preauthorized time frames. It is also the joint responsibility of the consumer and provider to determine what services

and tasks will best assist the consumer in achieving the objectives and goals. This approach to service and task planning maximizes consumer choice as well as consumer and provider accountability. For further clarification, see the Interpretive Guidelines, Section 02.b and this manual Section VI. Flow Chart and Detailed Procedures.

3. Working with Consumers and Providers:

Once the Service Plan has been completed, the RMHA assists the consumer in selecting a qualified provider or network of providers. Together the selected provider(s) and the consumer develops a Task Plan. A Task Plan includes the activities and time lines required to achieve the goals and objectives outlined in the Service Plan.

Teaching consumers in the target population to be knowledgeable about the services they need is also an important role for the RMHA. The RMHA is also available to providers to answer questions, train on Psychosocial Rehabilitation Services and related clinical issues, and improve the overall skill level of the private provider.

4. Managing Service Delivery for Quality and Outcomes:

The RMHA is responsible for monitoring individual consumer outcomes. This is accomplished through periodic reviews of consumer progress toward achievement of goals outlined in the Service and Task Plans and assessing consumer satisfaction with their provider. An RMHA staff person also works with the consumer and their provider(s) to periodically, but not less than annually, update the consumer's Comprehensive Assessment, as well as the Service and Task Plan.

RMHA ADMINISTRATIVE ROLES AND RESPONSIBILITIES

1. Identification of the target population

Once the RMHA has clinically identified members of the target population, it must establish, administratively, which consumers in the target population are eligible to be served with public funds. The adult and child target populations, as defined in IDAPA 16.03.09, consist of individuals within a specific range of diagnoses and levels of functioning. Where individuals most often differ is in the amount and type of resources they have to purchase mental health services. The RMHA works with consumers in the target population to determine if they can be served in the community using public resources, private insurance, or whether they would best be served directly through the mental health center provider.

Maintaining the integrity of the target population is crucial to managing care. It is the responsibility of the RMHA to provide training and technical assistance to staff and providers regarding characteristics of the target population, their needs, and the ' development of relevant services to meet the needs of this population.

Healthy Connections is a Medicaid-sponsored HMO-type program which gives Medicaid consumers the option of enrolling with a primary care physician. If the client has Medicaid and does not have a primary care physician, the RMHA can assist him or her in obtaining one. Individuals with serious mental illness should be encouraged to have a "medical home." This provides the consumer a personal relationship with a physician who knows his or her history, health needs, and is knowledgeable about other services the consumer is receiving. When a mental health consumer is a member of Healthy Connections, the RMHA must obtain authorization for Rehabilitative Services through the consumer's primary care physician. This requires the RMHA to establish and maintain a protocol for effective working relationships with primary care providers. As nonpsychiatrists, primary care providers may also benefit from education about the needs of the target population and the benefits of Rehabilitative Option services.

2. Preauthorization of Services

Provider agencies should contact the RMHA if they have an interest in providing Rehabilitative Services. The RMHA is available to assist prospective provider agencies in completing the Idaho Medicaid Provider Enrollment Application and the Medicaid Provider Agreement.

Provider agencies will negotiate with the RMHA the scope of services to be provided. The agreed upon scope of services will be described in the Supplemental Service Agreement. Supplemental Service Agreements for Community Support Providers are negotiated separately for adults and children**.**

During the initial negotiation of the Supplemental Service Agreement, the provider agency and the RMHA identify:

- The services to be provided;
- The region in which the provider agency is authorized to deliver services;
- The population (children or adults) the provider agency plans to serve; and
- What services the public mental health center will provide; e.g., after-hours coverage, training, psychiatrist.

Information from the Medicaid Provider Enrollment Application, Medicaid Provider Agreement and Supplemental Service Agreement is entered into AIM by the RMHA.

Entry into AIM triggers EDS to send information to the provider agency; e.g., a provider number and billing information. The original documentation is maintained by the RMHA.

3. Working With Consumers and Provider Agencies

It is the role of the RMHA to work with both current and potential provider agencies to assure regional community-based systems of care are adequate to meet the needs of the members of the target population. In the current market, it is a challenge to recruit Medicaid provider agencies. Some of the primary barriers include, but are not limited to: relatively low reimbursement rates; lack of provider expertise in working with the target population; and provider agency's desire to continue providing clinic-based services only. It is important to work with individual agencies to help them identify the benefits of becoming a Medicaid provider for the Rehabilitative Option; e.g., diversification, flexibility, responsiveness to consumer needs, and preauthorized services which help to protect the provider agency from recoupment.

In order to develop trust with both consumers and provider agencies, it is important that the RMHA staff be consistent, set clear expectations, give feedback in a timely manner, be open to receiving feedback, and be responsive to consumer and provider agency concerns. It is also the responsibility of the RMHA to inform both consumers and provider agencies about their administrative appeal rights in the event that they disagree with any appealable decisions made by the Department (**Attachment 2**).

It is also the role of the RMHA to work with consumers to increase their skills and abilities to effectively use services. This includes empowerment strategies such as consumer participation in service planning, provider selection, and evaluation of provider services. Another important and recent innovation to help consumers develop natural supports is development of their collective capacity to deliver services to each other and to support and advocate for each other.

Each provider agency is responsible to market/advertise the services they provide. Provider agencies may leave brochures advertising their services at the mental health center. However, the RMHA will not actively solicit consumers for any particular provider agency. Each consumer who receives a Comprehensive Assessment will be given a listing of all provider agencies which includes agency staff, location, and services the agency is authorized to provide. Outcome data on provider agencies will also be made available to consumers. Consumers will be free to select their providers. **Attachment 1** contains a detailed policy statement regarding inappropriate solicitation**.**

Attachment 1: Policy Regarding Inappropriate Solicitation of Consumers by Provider Agencies

4. Managing Service Delivery for Quality and Outcomes

The RMHA is responsible for establishing and maintaining a quality improvement system based on the cumulative results of individual consumer outcomes and consumer satisfaction. This data can be used to: (1) renegotiate provider agency agreement, and (2) publish provider agency outcome statistics to assist consumers in selecting a provider.

The RMHA is concerned with provider agency accountability for positive consumer outcomes and appropriate use of resources. At least annually, the RMHA will review agency records. The review will verify authorized services are leading to positive outcomes (consumer satisfaction and consumer outcome measures). The RMHA will also review records to ensure services have been provided in accordance with the Service Plan (billings match services). The RMHA will use this data in the annual renegotiation of the Supplemental Service Agreement.

V. SPECIAL TOPICS

DEVELOPING PARTNERSHIPS

The relationship between the RMHA and private provider agency is best characterized as a partnership. A partnership is a negotiated sharing of responsibility based on a verbal or written contract. Partners agree to be involved as active participants in mutually determining goals and tasks that promote health, growth, and well-being of consumers. The RMHA- private provider agency contract is the Supplemental Service Agreement.

As partners, the RMHA and the provider agency play different roles in achieving an overarching goal. Their shared goal is provision of appropriate, cost-effective, quality services to consumers within the target population. The RMHA and the private provider agency also come to the partnership with different, but related, interests, and perspectives. Development of successful partnerships requires mutual understanding, collaboration, and respect for the interests and perspectives of the other.

Private provider agency interests may include: effective business management; profit; quality of services; flexibility (how, where, who, what); providing more comprehensive services thereby making the business more financially feasible; motivation to serve consumers; ability to rapidly respond to changing consumer needs; preventing consumer hospitalization; and avoiding recoupment by having a clear procedure and a preauthorization for all services delivered.

RMHA interests may include: Developing an integrated system of care; focusing the expenditure of public funds on the target population; relevant consumer services; achievement of positive outcomes; monitored quality of care; effective gatekeeping; availability of a greater range of consumer choice through diversity of providers; preventing hospitalization; developing

community-based alternatives; and encouraging self-reliance.

Some of the **shared interests and values** may include: Good quality of community-based care; sharing responsibility for direct care; expansion of services; prevention; pro-active interventions offered through the Rehabilitation Option; e.g., skill development; positive focus on a comprehensive approach to assessment and treatment; creativity; and consumer independence.

Collaboration, another key to successful partnerships, typically requires changes in the way each participating organization functions. Decision making and planning must be shared. Collaborating organizations commit budget, personnel, and other resources to be managed by an entity that represents the partnership;i.e., the RMHA.

Historically, the primary role of publicly funded community mental health was providing direct services. **DHW (public mental health) now has multiple roles** which include: Facilitator of service system development; partner of the provider agency; direct service provider to the consumer; oversight and management of services; empowerment role with consumers; responsible stewards of public resources; mediators of consumer/provider and provider/provider conflict; and trainer of provider agencies.

Conflict most often occurs when the roles of parties in a relationship change. It is sometimes tempting for each party to devalue the interests and motives of the other. This can result in a polarizing of positions rather than seeking shared interests. One of the roles and interests of the RMHA is to ensure that relationships are valued and nurtured.

CONFLICT RESOLUTION

Prior to the Rehabilitative Option, the Department's primary role was to provide direct services to consumers. Under the Rehabilitative Option, the Department has a new role, that of managing service delivery. That role now involves two entities to whom the Department has responsibility, the individual consumer and the private provider agency. All the relationship skills previously used to provide direct services are valuable. They must now be applied to working with complex clinical and administrative systems to assure effective services are delivered to the consumer.

One of the primary goals of the Rehabilitative Option is to enhance services to the target population by forming public-private partnerships. These partnerships require relationship building skills including clear and assertive communication, WIN-WIN problem solving, and conflict management. Conflicts can arise around both service and administrative issues. Types of potential conflict might include the following:

> **Structural Conflict** may arise from aspects of a system beyond the control of the individuals involved; e.g., rules, laws, institutional arrangements (bureaucracy), overlapping authorities or unequal control over resources). A suggestion to address

structural conflict is open and honest discussion. This helps parties understand their structural dilemma and helps avoid development of personal animosity. The parties, the RMHA, the consumer and the provider agency may develop ways of coping with their situation even though they may be powerless to change the system arrangement;

Value-Based Conflict may arise from deeply held value differences. These differences are usually reflected in absolute terms or rigid moral positions; e.g., the value of psychotherapy and/or consumer empowerment vs. the "expert" model. A suggestion to address value-based conflict is to appeal to more widely held or other values; e.g., the value of outcome measurement. Focus the parties on common ground they share or encourage them to recognize the importance of both values, even if they are not shared. Resolution may be that the parties agree to disagree;

Interest Based Conflict may arise from competition over perceived or actual incompatible needs such as competition between provider agencies for a consumer, and/or role change from therapist to manager. Interest based conflict is material in nature. One suggestion for addressing interest based conflict is compromise through negotiation, especially when people are competing for the same resources. People may also be willing to forego one type of interest in return for having another interest met; i.e., "quid pro quo;"

Relationship Conflict arises for a number of reasons including misunderstandings, frustrations, parties feeling they have not been included, consulted, treated with respect, given appropriate attention or treated as equals. This type of conflict may be indicative of a deeper issue. Typical examples are parent-child conflict, employee disputes, personality conflict between the RMHA and a provider, and consumer-provider conflict. Relationship conflict is emotional in nature. It is important to distinguishing between issues which can respond to problem solving and those that need intra-personal emotional resolution. Being valued and accepted by the other party may be as or more important than agreement on content; and

Information Conflict may arise when there are differences in the type and/or amount of information exchanged or held by two or more parties; e.g., changes in policy are not communicated to everyone. One suggestion for addressing information conflict is the mutual agreement on development of processes for ensuring all parties have the same information.

When attempting to resolve conflict informally, the RMHA should use the following process:

1. Identify the parties in conflict and identify the Department's role as a party or a neutral;
2. Identify the type of conflict;
3. Convene the parties with or without facilitation/mediation;
4. Define the conflict from the perspective of each party and validate them as persons;
5. Explore options;
6. Agree on a solution or course of action which ideally satisfies all parties' interests;
7. Write agreements down so that each party's actions, role and responsibility is clear; and
8. Follow-up and evaluate progress.

Employ active listening and clear and assertive communication throughout the process. Focus on WIN-WIN problem solving that strives to preserve relationships.

Conflict can be resolved through both informal and formal processes. An informal process, such as the one described above, should be used whenever possible and early in the conflict. Experience says early, informal attempts at conflict resolution result in faster, less expensive outcomes that also do a better job of preserving relationships. Timely conflict resolution also helps avoid delays in consumer service delivery. Use of an informal process should not deny the parties' right to a formal process, such as a fair hearing.

An article on conflict resolution as a method for handling disputes related to managed service delivery can be found at Attachment 26. The article focuses on the importance of role clarification and that conflict resolution is a part of managed service delivery.

Attachment 26: Applying A Conflict Resolution Framework to Disputes in Managed Care

ADMINISTRATIVE APPEAL

The Department of Health and Welfare has a formal method of problem solving called the administrative appeal process. The rules which describe this process, Rules Governing Contested Case Proceedings and Declaratory Rulings are found in IDAPA 16.05.03.

A section with a detailed description of the appeal process will follow the publication of this manual. **Attachment 2** will contain materials necessary to assure consumers are knowledgeable about their appeal rights. Currently Attachment 7 does include established procedures for Family and Children's Services.

SUPERVISING PRACTICE

Education, supervision, and support of Department staff are critical to developing and maintaining successful partnerships with private provider agencies and to helping achieve positive outcomes for consumers.

When supervising direct service staff, supervisors need to be alert to two critical issues which are frequently problematic. The first is identification (or misidentification) of target population members by including individuals who are not members of the target population. The second is failure to clearly identify and articulate consumer issues, goals, and objectives based on the comprehensive assessment. Without this clarity, task planning will not likely help the consumer accomplish their goals.

At the **initial screening stage**, supervisors should be asking workers questions about how the consumer meets the criteria for the target population.

At the **comprehensive assessment** stage, the RMHA and the individual consumer, or the child and family identify the degree of functional impairment in specific life areas; e.g., housing, family, education/employment and a diagnosis, if needed. Supervision should focus on medical necessity of the services, the degree of functional impairment, and whether or not rehabilitative services will address the needs of the individual or, in the case of a child, the child and his or her family. Medical necessity is further described in **Attachment 3.**

Attachment 3: Defining "Medically Necessary" Services to Protect Plan Members
Defining "Medically Necessary" Services to Protect Children

Suggested supervisory considerations in review of **Service Planning**:

- Was the consumer/family involved in the planning?
- Do the proposed services relate directly to the needs and issues identified and prioritized in the assessment?
- Do the goals and objectives relate to the needs **identified by** the consumer/family?
- Has the worker assisted the consumer/family to make informed choices?
- In the planning process, have measurable outcomes been identified? Are these outcomes reasonably achievable by a private provider?

- Are services being provided that have had no positive outcomes for the consumer in the past?

- Are the preauthorized hours reasonable to accomplish the objectives/outcomes?

DUAL DIAGNOSIS OR OTHER CROSS-PROGRAM ISSUES

Close coordination is important. The consumer should experience a coordinated, helpful and sensible delivery of services. The Department's goal is to minimize cost and service shifting by working together to share costs. The initial step is to develop an appropriate plan with the consumer and then work to resource that plan.

When adult or juvenile corrections are involved with a consumer, the consumer must be held accountable for their conduct and community protection must be assured along with access to mental health services. This requires a collaborative effort. Mental health treatment, per se, cannot sanction behavior, legal or illegal. Treatment may, however, be able to help resolve some of the concurrent mental health issues.

Some fact situations which call for close coordination of services:

- Persons with severe mental illness and substance abuse issues;
- Children being served by multiple programs including, but not limited to: DD, school, CMH, and EPSDT;
- Children with a diagnosis of Autism;
- Children and adults with developmental delays who commit sexual offenses;
- Transition of children with a serious emotional disturbance from institutions back into their communities; and
- Adults receiving rehabilitative services in addition to clinic and/or targeted case management.

VI. FLOW CHART AND DETAILED PROCEDURES

Procedures and forms need to be consistent so consumers are not confused or inconvenienced by regional variation and that Medicaid policy and rule are being consistently interpreted and administered. Many of the tools referenced in the text are required and labeled "Required Tools." Those which are a regional option and can be revised are marked "Optional Tools."

The following flow chart highlights major clinical and administrative functions of the RMHA and the Rehabilitative Services model. The Clinical Track addresses interactions between the RMHA and the consumer. The functions described in the Administrative Track address interaction between the RMHA and the provider agency. Each step on the flow chart is further

described in the following text. The flow chart and text share the same step identifiers (i.e., 1, 2, 3 or A, B, C).

Attachment 4 : Flow Chart for Rehabilitative Option Services Process

CLINICAL TRACK

A. CLIENT APPLICATION FOR MEDICAID

Medicaid applications can be obtained at any DHW regional field office from the Self-Reliance Program. The applicant will be given a list of necessary documentation to bring to his or her first appointment. That appointment with a Self-Reliance Specialist will be scheduled to review the application and supporting documentation. This is an excellent time for the Medicaid eligible consumers to talk with a Self-Reliance worker about getting enrolled in Healthy Connections, if this is what the consumer desires and it is available fo the consumer.

Adoption Assistance Agreements - When a parent reports their child has a IV-E Adoption Assistance Agreement, the parent should be immediately directed to the regional Family and Children's Services office. They **do not** need to fill out a Medicaid application because they will probably have reciprocal Medicaid coverage from another state through the Interstate Compact on Adoption and Medical Assistance (ICAMA). If you are unsure what to do with the parent and child with an Adoption Assistance Agreement, please contact a regional adoption worker or call the Adoption Program Specialist at Central Office (208) 334-5700.

B. CLIENT APPLICATION FOR MENTAL HEALTH SERVICES AND INITIAL SCREENING

Generally consumers apply for services via several routes. They can be self referred, referred by an agency currently providing services to the consumer, or by someone else in the community. An initial screening interview is scheduled. Material needed at the initial screening interview includes: Medicaid Card, releases of information for prior treatment episodes, proof of Social Security and proof of Healthy Connections or other insurance carrier. If the referral is made by the consumer's current provider, the RMHA may require the provider to send the information identified by the Psychosocial Rehabilitative Services Referral (**Attachment 5**) and send it with the consumer to the initial screening interview.

Attachment 5: Psychosocial Rehabilitation Services Referral

Following the screening interview, if it is determined the consumer could likely benefit from Rehabilitative Services and the consumer is a Healthy Connections participant, the RMHA assures contact is made with the client's Healthy Connections physician to request a referral for Rehabilitative Services. The physician should receive a copy of the Comprehensive Assessment and Service Plan when they are completed.

If a client is a Healthy Connections participant, a referral from the physician for mental health services is needed before any services, including the Comprehensive Assessment, can be billed to Medicaid. A sample of the Healthy Connections Referral Form can be found in **Attachment 6**. It is important to set up a local protocol for working with Healthy Connections Primary Care Physicians to facilitate smooth and timely interfaces and referrals.

Attachment 6: Healthy Connections Referral Form- REQUIRED FORM

C. APPROPRIATENESS FOR PSYCHOSOCIAL REHABILITATION SERVICES

During the initial screening interview, a preliminary determination is made whether the applicant is likely to meet the eligibility criteria of the target population as defined in the Psychosocial Rehabilitative Services Interpretive Guidelines (**Attachment 18**) and in the Supplemental Services Agreement(s) (**Attachment 15**). For children, there is also a brief Application for Services (**Attachment 7**) which the parent(s) must complete. When the applicant is determined not to be a member of the target population, community referrals are made. The parents do receive a written Notice of Decision (**Attachment 7**) which explains the basis of the child's ineligibility and information regarding their appeal rights.

Attachment 18: Rehabilitative Services Interpretive Guidelines - REQUIRED TOOL

Attachment 15: Supplemental Services Agreement - Adult Version - REQUIRED TOOL

Attachment 15: Supplemental Services Agreement - Child Version - REQUIRED TOOL

Attachment 7: Application for Services (children only) - REQUIRED TOOL

Notice of Decision (children only) - REQUIRED TOOL

D. COMPREHENSIVE ASSESSMENT, SERVICE PLANNING AND PHYSICIAN SIGNATURE

If, in the initial screening, the consumer/child and family is determined likely to be a member of the target population, and appropriate for Psychosocial Rehabilitative Services, a **Comprehensive Assessment** (**Attachment 9**) is scheduled to be completed by RMHA staff. When appropriate, a Service Plan is then also completed by RMHA staff.

Consumers/child and family will be assessed, face to face, on Psychiatric/Developmental History, a Mental Status Exam and each of nine functional domains by a staff member of the RMHA. Collateral contacts will be made with other sources including family members, previous assessments/testing, hospital records, landlords, friends, schools, previous providers, etc. The Comprehensive Assessment is more than a recording of the consumer's report; e.g., "I haven't worked in three years." It involves collecting pertinent information and integrating that information to determine the effects of the consumer's illness on each domain and how these factors impact the consumer's ability to function within his or her family or independently.

Service Planning involves the RMHA staff member collaborating with the consumer/child and family to develop a plan which establishes the issues/concerns for which the consumer is seeking DHW services, the goal and the individual's or family's behaviorally specific and measurable objectives.

The RMHA staff will also provide information to the consumer/child and family enabling them to select a provider who will best meet their service needs. During the assessment and provider selection process, the RMHA should help facilitate a primary working relationship between the consumer and the provider(s) of their choice.

During the development of the Service Plan, a baseline for individual outcome indicators will be completed (**Attachments 19 and 20**).

Attachment 19: Adult Outcome Indicators - REQUIRED TOOL

Attachment 20 : Child and Family Outcome Indicators - REQUIRED TOOL

A meeting with the nurse may also be scheduled if the adult consumer is taking neuroleptic medication. During that appointment with the nurse, adult consumers will be assessed for possible side effects to medication through completion of the Assessment of Involuntary Movement Scale (AIMS) (**Attachment 12**).

If the consumer is Medicaid eligible, a Service Plan is completed and the consumer will be given a copy of the Service Plan and a list of Medicaid approved provider agencies to choose from to complete the Task Plan. If the client is not Medicaid eligible, the public mental health center

will provide services, either directly or through a contract.

The Comprehensive Assessment will identify domains in which the client has identified issues/needs. The primary issue within each applicable domain should be clearly stated. A measurable objective(s) is then developed with the consumer/child and family. This information is then written into the Service Plan. When the Service Plan is completed, the Department physician signs the Service Plan indicating the services are medically necessary.

Attachment 9: Adult Comprehensive Assessment Outline - REQUIRED TOOL **Children's Comprehensive Assessment Outline - REQUIRED TOOL**
Attachment 10: Service Plan for Adults - REQUIRED TOOL
Attachment 11: Service Plan for Children - REQUIRED TOOL
Attachment 12: AIMS Protocol - REQUIRED TOOL

SPECIAL CONDITIONS WHICH DO NOT REQUIRE PREAUTHORIZATION: CRISIS SERVICES

Once the consumer has been determined to be eligible for Rehabilitative Services, crisis hours can be approved for the following crises: to prevent loss of housing, employment, reduction of income; and/or when there is a risk of incarceration, physical harm, family altercation; and/or other emergencies.

Crisis hours must be authorized. The initial crisis contact must be approved by the RMHA the morning of the next business day following the services. The RMHA will review each crisis after the fact to make a determination about clinical appropriateness and financial reimbursement. Crisis hours are limited to a maximum of four (4) hours per day during a period of five (5) consecutive days and must be preauthorized by the RMHA. Different methods may be used to request crisis hour approval. The Request for Community Crisis Support Hours form (**Attachment 8**) may be used or the provider may fax the RMHA a progress note containing the same information as the request form. The RMHA enters the authorization into AIM which results in the provider agency receiving a Prior Authorization (PA) letter from EDS. This PA is required before the provider agency may bill for the service. Providers should keep letters of crisis authorizations received from EDS in the record.

Once the Service Plan is completed and signed, authorization for crisis hours may be requested by the process described above. When the crisis is resolved, the provider should contact the RMHA by fax or mail with a description of the crisis, action taken to resolve it, contributing factors, and a strategy to address the relevant factors and prevent similar crises in the future. It is important to attempt to resolve crises by using activities specified in the consumer's Task Plan

before requesting crisis hours. The Task Plan usually contains activities and plans to deal with symptom management and problem-solving techniques for these types of events.

Attachment 8: Request for Community Crisis Support Hours form

SPECIAL CONDITIONS WHICH DO NOT REQUIRE PREAUTHORIZATION: EMERGENCY ROOM SERVICES

Crisis services may be provided in an Emergency Room (ER) during an evaluation process if the goal is to prevent hospitalization and return the consumer to the community. Services are not reimburseable after the person has been admitted to the hospital other than the ER. Crisis services provided in an ER are billed under a separate code from Community Crisis Support and must receive additional prior authorization. When services are provided in the ER, the RMHA must be notified by the next working day. A prior authorization for community crisis support **will not** cover the billing for services provided in the ER. This task (5008H) and community crisis support services (5000H) have different service codes. The correct code number will be entered into AIM for an IPA number that is used for billing purposes. A copy of this AIM Prior Authorization number will be sent to the recipient and the provider.

E. PROVIDER SELECTION

The RMHA maintains a list of approved Medicaid Rehabilitative Services provider agencies, a description of the services they provide and a report of their effectiveness based on consumer satisfaction and outcome indicators. The list of provider agencies is given to consumers during development of the Service Plan so the consumer can begin to select provider(s). A copy of the Comprehensive Assessment and Service Plan are then forwarded to the selected provider(s).

Providers may refer consumers to the RMHA for assessment. In these cases, the consumer may choose the referring provider or any other qualified provider for ongoing services. The RMHA may need to mediate the situation if a consumer chooses a provider other than the referring provider. Consumers should be empowered to ensure they have a choice of providers. The RMHA needs to advocate for the consumer and at the same time explain the issue of choice to providers to assure their understanding.

F. TASK PLAN DEVELOPMENT

Upon completion, a copy of the Comprehensive Assessment, Service Plan, and blank Task Plan are sent to the consumer's selected provider(s). If the providers(s) feel changes need to be made to the goals, objectives, and/or hours authorized, these changes must be negotiated with the RMHA before the Task Plan is completed.

Upon receipt of the Service Plan, the providers(s) meet with the consumer to develop a Task Plan to achieve the identified objectives. Tasks should be very specific about the service, the place of service, the duration of service and the provider.

Attachment 13: Task Plan (blank form) - REQUIRED TOOL

G. RMHA APPROVAL

Upon completion of the Task Plan, it should be returned to the RMHA. The RMHA should enter all approved services into the AIM system. This allows the provider agency(s) to receive a letter authorizing them to bill for the approved services. With the issuance of each PA, the consumer also gets a copy of the PA with their appeal rights described on the reverse.

The consumer can choose services and provider(s). Providers can also choose whether or not to serve a particular consumer.

H. IMPLEMENT PLAN

After the Task Plan has been approved by the RMHA and returned to the provider agency, the provider agency may begin providing the preauthorized services. The provider is to retain a copy of the Service Plan, the original Task Plan and the Comprehensive Assessment in the consumer's record.

The provider agency is responsible for developing the following information for consumer review and signature:

1. How to contact the RMHA to have an informal opportunity to discuss issues including additional provider referrals and/or change of provider (see section 4.3 of the Supplemental Service Agreement);

2. Document that the consumer was informed about protection, advocacy, and legal assistance services;

3. The agency will develop a transition plan and give at least 30 days notice to the eligible consumer and the RMHA when terminating mental health services. The agency will assure a timely and appropriate transition by identifying alternative providers for the consumer. The agency may not terminate services when the RMHA determines that to do so would pose a threat of endangerment to the consumer or others.

Service Record Documentation

Provider agency service delivery documentation must contain the following: the name of the consumer; the name of the provider agency; the signature, degree/title of the person providing the service; the date, time, and duration of the service; the service(s) provided; and how the service(s) relate to the objective, the outcome, and next steps.

Suggestion: Although it is not required in Department administrative rules or interpretive guidelines, a useful method of record keeping is called P-I-E charting. P-I-E stands for Problem, Intervention and Evaluation. Each note should state why you are seeing the consumer (P), what rehab interventions you engaged in with the consumer (I), and your evaluation of the consumer's response to the interventions (E). Interventions need to be directed toward a specific type of skill training. It is important to indicate the specific instruction you are giving the consumer and what their response is to that instruction. The S.O.A.P., NAP or other similar documentation methods can be used.

There is an important distinction between Adult Targeted Case Management activities and Psychosocial Rehabilitation activities. The language used in the case notes should be consistent with the following descriptions:

Adult Targeted Case Management activities including, but not limited to, linking, arranging, advocating, monitoring, and assisting; and

Psychosocial Rehabilitation activities including, but not limited to, instructional modeling, demonstrating problem-solving training service, structured training.

PREMATURE TERMINATION OF SERVICES

If the provider agency terminates services for any reason; e.g., moving, not returning, lost Medicaid eligibility, incarceration, poses a safety risk to your staff or other consumers, etc., the provider must immediately notify the RMHA in writing so consumer services can be maintained. The RMHA must terminate or "end", in AIM, any outstanding Prior Authorizations (PA's) for

that provider/consumer.

CASE TRANSFER BETWEEN RMHA's

From time to time, consumers move from one region to another. The goal is optimal maintenance of continuity in the provision of services from one location to another. Steps which must be completed are:

1. RMHA preparation of the consumer to the extent possible; e.g., who to call at the new RMHA;
2. The region which first learns of the consumer's relocation should initiate communication with the other RMHA and begin the record transfer process;
3. The sending region must put an end date on all current PA's in AIM for that consumer;
4. The receiving RMHA should review the current Comprehensive Assessment and Service Plan with the consumer and determine if the assessment and plan continue to be appropriate for the new location. Any necessary updates will need to be completed;
5. The consumer will choose a provider eligible to provide services in the region where the consumer now lives;
6. The consumer and the new provider should review the previous Task Plan and determine what, if any, of the tasks now apply to the current Service Plan;
7. Upon approval of a Task Plan, the receiving RMHA must enter all necessary PA's into AIM. These PA's will reflect the new RMHA and the new provider; and
8. The RMHA may authorize collateral hours to facilitate communication between the new and the previous provider for the purpose of continuity of care.

I. CLINICAL REVIEW PROCESSES AND OUTCOME EVALUATION

Plan Amendments

"When change is required that necessitates an addendum or revision to the existing plan, the PROVIDER will assure that the revised plan is reviewed and authorized by the RMHA prior to the delivery of services." See Supplemental Service Agreement, section 3.5; c - **Attachment 15**.

Service and Task plans may be amended anytime. It is appropriate to amend the plan to provide more effective services to the consumer. Amending plans does not restart the clock of the

original plans or change the dates on which reviews are to be conducted. Plans may be amended to address the following:

Issues
Objectives
Tasks
Hours

Amending Service and Task plans requires the following steps:

1. Amendments/changes to the Service Plan and/or Task Plan require a stated rationale for the change. The provider should discuss with the RMHA or mail the request for a change to the RMHA. Justification for the request for change in services should be included. In addition, the provider should complete the desired amendment to the Service and/or Task Plan. Time spent on Amendments to Service and/or Task Plans is a reimbursable activity. This time is considered Service and/or Task Plan development activities and is billed as Task Plan Development (5007H). The consumer or child and family must participate in the development of the plan, sign and approve the plan;

2. The RMHA will review and verify the need for the requested changes with the consumer. The RMHA will then determine whether to approve or deny the change, and negotiate with the provider agency if necessary. The provider agency may begin billing after receipt of a prior authorization letter to cover the services outlined in the amendment;

3. The RMHA will complete the amendment to the Service Plan and the provider will complete the amendment to the Task Plan; and

4. Amended plans require the following signatures.

Type of Change	**Client Signature**	**Agency Signature**	**Physician Signature**	**RMHA Signature**
Issues	**x**	**x**		**x**
Objective	**x**	**x**		**x**
Task, no changes in objective or hours	**x**	**x**		**x**
Increase in Hours	**x**	**x**	**x**	**x**

120 and 240-Day Reviews of Progress

A 120-day review and 240-day review must be completed by the provider on or before the date specified on the Adult Service Plan Cover Sheet and on the Children's Service Plan. The review must document the progress toward the consumer's goal(s) and for each objective by issue area. Documentation should specify the consumer's continued need for services. **The reviews will be done with the adult consumer or child and family.** This activity is billed as **Individual Psychosocial Rehabilitation, NOT as Rehabilitation Evaluation.** I.D.A.P.A. rules specify that progress toward goals is to be assessed. The provider should document progress toward goals by assessing consumer progress on each behaviorally specific objective. When all objectives specific to a goal are accomplished, the goal will have been met. A sample Review Form is included as **Attachment 14**. This sample contains all required elements. The specific format is regionally defined. The completed review forms will be kept in the provider's consumer file. They will need to be made available to RMHA staff upon request.

Attachment 14: - Review Form (sample) - OPTIONAL TOOL

Annual Comprehensive Assessment Update and New Service Plan

Approximately 45-60 days prior to the due date for the annual Service Plan review, the RMHA will schedule an appointment with the consumer for an update of the Comprehensive Assessment and creation of a new Service Plan. If a new Healthy Connections referral is required, the consumer should be asked to bring it to the appointment. Prior to the appointment, the consumer and provider should complete the Psychosocial Rehabilitation Outcomes Survey. A copy of the Outcomes Survey should be forwarded to the RMHA. In preparation for the annual update, the RMHA will provide the consumer or family with a Consumer/Family Satisfaction Survey which is to be returned to the RMHA by the consumer/family.

Attachment 19: Outcome Indicators - adults REQUIRED TOOL

Attachment 20: Outcome Indicators - children REQUIRED TOOL

Attachment 21: Adult Consumer Satisfaction Survey REQUIRED TOOL

Attachment 22: Child and Family Satisfaction Survey REQUIRED TOOL

The RMHA will enter all indicator and satisfaction information into a statewide ACCESS database. This database will allow the RMHA to monitor overall implementation of the Rehabilitation Option. Specific provider and aggregate provider agency outcomes, and consumer satisfaction levels will be calculated. It is critically important to be as accurate as possible when completing these tools. In the event a consumer needs assistance completing the

Consumer or Family Satisfaction Survey, a best practice recommendation is to have the case manager or someone other than the provider assist the consumer. Most RMHA's administer the Consumer or Family Satisfaction Survey during the reassessment.

Items the consumer needs to bring to the annual update interview:

Healthy Connections referral form, if required; and
Medicaid card.

Immediately before the appointment, the consumer will be asked to complete an update of his or her Fee Determination and adult consumers will have an AIMS test done by a Community Mental Health Center Registered Nurse. The RMHA staff interviewer will review the Psychosocial Rehabilitation Outcomes form and collect information required to update the Comprehensive Assessment. The interviewer will then complete the Service Plan by listing the goals, issues and objectives the client identifies for the upcoming year. The consumer will discuss with the interviewer his or her desire to retain their current provider or select a new provider(s). A copy of the updated assessment, new Service Plan and a blank Task Plan is then sent to the selected provider(s).

In most cases, two hours are authorized for development of the new Task Plan. **No additional services will be authorized at this time,** as the consumer's current service plan is in effect pending signing of the new Plan.

Developing the new Task Plan

Once the provider and consumer have completed the Task Plan and negotiated any Service Plan issues with the RMHA, they will sign the Task Plan. The provider will send a copy of the completed Task Plan to the RMHA for review and signature. Ideally, this process should be completed before the Service Plan expiration date. Each new Task Plan should routinely include one hour for the completion of the outcomes indicator instrument so these hours will not need to be specifically requested in the future.

ADMINISTRATIVE TRACK

1. IDENTIFY POTENTIAL PROVIDER AGENCIES

A regionally specific plan for identifying and approaching community provider agencies as potential Rehabilitative Option providers can be useful.

One innovative strategy in recruitment of Rehabilitative Services provider agencies is consideration of non-traditional providers who provide the following types of services: homeless, vocational, companion, parenting education. Another strategy is to work with traditional clinic providers on how they can more effectively serve their current clientele through the addition of Rehabilitative Option Services while at the same time retaining their current level of billable hours.

Provider workshops are also an excellent venue for meeting and developing community provider agencies.

2. PROVIDER ENROLLMENT

The Medicaid Provider Enrollment Application, Agreement and the Supplemental Service Agreement, signed by both the provider and the RMHA, establish the services for which the provider can be reimbursed.

INSTRUCTIONS FOR MEDICAID PROVIDER ENROLLMENT APPLICATION

There are specific requirements for the Medicaid Provider Enrollment Application outlined below. These applications can be obtained through the RMHA or by contacting EDS at 1-800-685-3757.

Insurance
If required to carry Workman's Compensation Insurance, attach a copy of your policy. Also, attach proof of Professional Liability/Liability Insurance coverage. The policy numbers must be included on the Enrollment Application.

Employees
Provide the full name, Social Security number, and attach a copy of current licenses of all employees or contract staff who will be providing Rehabilitation Option Services. If an individual is not licensed, submit a copy of their transcripts, diploma, and current resume with the agreement. It is the responsibility of the RMHA to determine who will be authorized as a qualified provider agency. If the provider agency disagrees with this decision, the decision can be appealed.

Specific Medicaid Provider Enrollment Application Items
Item: Provider Type. Check Rehabilitation Option
Item: Provider Specialty. Check Rehabilitation Mental Health service.
Item: Special Characteristics. List Adult or Child.

Working with children under the Rehabilitation Option requires a separate Medicaid Provider Enrollment Application Packet including the Supplemental Service Agreement. Targeted Case Management and Mental Health Clinic Services require separate Medicaid applications. The provider is also required to complete a Medicaid Provider Enrollment Agreement which must be authorized by the RMHA and remains on file with the RMHA.

Attachment 15: Medicaid Provider Enrollment Application Packet - REQUIRED TOOL

Supplemental Service Agreement

It is the responsibility of the Program Manager or designee to negotiate the terms of the Supplemental Service Agreement. During the initial negotiation, the provider agency and the RMHA identify:

The services the agency will provide;
The region in which the agency is authorized to deliver services;
The population (children or adults) the agency plans to serve; and
What services the public mental health center will continue to provide; e.g., after-hours, training, psychiatrist.

The agency should be reminded of the criminal background check requirement. In the Supplemental Services Agreement section 5.7 for both children and adults, it states: "The AGENCY shall be responsible to verify that all employees, subcontractors or agents coming into direct contact with eligible recipients have completed a criminal history check." The provider agency is also responsible for the costs of the background check. Currently, DHW is conducting the checks. See **Attachment 27:** DHW Policy Memorandum 97-6, Criminal History Background Checks. Also see IDAPA 16.05.06: Rules Governing Mandatory Criminal History Checks and Rules Governing Family and Children's Services 16.06.01.004: Mandatory Criminal History Checks.

Attachment 15: Supplemental Service Agreement (adults) REQUIRED TOOL

Attachment 15: Supplemental Service Agreement (child) REQUIRED TOOL

3. ENTRY INTO AIM

The RMHA enters all provider information (Medicaid Provider Enrollment Application, Medicaid Provider Enrollment Agreement, and Supplemental Service Agreement) into the AIM system. This includes the start and end date of the agreement This action by the RMHA enrolls the provider agency. The AIM system then assigns a Rehabilitative Option provider number. EDS sends the provider a billing manual. A current fee structure for Medicaid Reimbursement

for Rehabilitative Services is included in **Attachment 16**.

Attachment 16: Current Fee Structure - REQUIRED TOOL

When Supplemental Service Agreements are renewed, the RMHA enters a new start and end date into AIM on the PRGI screen. If the agreement is terminated, the RMHA must assure the end date of the agreement has been entered into AIM. This will prevent the provider agency from being able to be reimbursed past the end date.

4. IMPLEMENTATION SUPPORTS FOR PROVIDERS and THEIR AGENCIES

Support, Training and Technical Assistance for Providers

The RMHA may provide training and technical assistance to providers to help them better address the needs of members of the target populations and to strengthen partnerships. Training and technical assistance generally fall into two categories, clinical and administrative. Clinical training and technical assistance may include providing the most current information on which to base treatment decisions and providing appropriate skills training. Administrative training and technical assistance may include clarifying issues and answering questions about processes and procedures such as billing, documentation, accountability, and information dissemination. The methods of training and technical assistance may include individual consultation, multiple provider trainings, participation in statewide and national trainings, mentoring, and other provider support and service development.

The RMHA will also seek feedback from the provider agency about RMHA support and compliance with the Supplemental Service Agreement and what the provider may need from the RMHA in order to support their success.

5. ADMINISTRATIVE REVIEW PROCESSES and OUTCOME EVALUATION

The RMHA will conduct quality assurance visits at least annually. Although most visits will be scheduled in advance, the RMHA may conduct these visits without prior notification. Written feedback will be sent to the provider within 30 days of the visit. A sample Quality Assurance

Review form is contained in **Attachment 17.** The purpose of the visits is to assure the following:

- Positive consumer outcomes, satisfaction and quality of services
- Compliance with the Supplemental Services Agreement
- Accuracy of provider agency billing

Attachment 17: Quality Assurance Review Form - OPTIONAL TOOL

Each provider agency is responsible for understanding and complying with the Supplemental Service Agreement. Although not all provisions from this agreement are listed, the following includes routine information to be considered during a quality assurance visit:

Positive Consumer Outcomes, Satisfaction and Quality of Services
When reviewing service delivery, the RMHA will consider the following:

1. Frequency and nature of contacts with the consumer are consistent with the Service and Task Plans;
2. The client's goal(s) and objectives are being achieved and public funds are being utilized efficiently;
3. Unless otherwise specified in the Supplemental Service Agreement, agencies have 24-hour response capability;
4. Consumers and the RMHA are receiving at least 30 days notice of termination of services as well as a copy of the transition plan to insure a minimal lapse in service continuity; and
5. Accurate and timely documentation.

Compliance with the Supplemental Service Agreement
The Supplemental Service Agreement is reviewed annually by the RHMA and the provider. This is an opportunity to examine the adequacy of the current agreement and how well the provider and the RMHA have implemented the agreement. Modifications are then made accordingly. It is the option of the RMHA to not renew a Supplemental Service Agreement, if the provider agency has consistently failed to adequately provide the services identified in the Agreement. More often, the RMHA provides technical assistance to support the provider in meeting the intent of the Supplemental Service

Agreement.

As part of oversight authority, the RMHA can revoke a provider agreement, not renew a provider agreement, or take additional measures based on a finding of fraud or gross noncompliance such as hiring unqualified individuals, including employees with a positive criminal history check and no exemption review. The RMHA must involve Medicaid's Surveillance and Utilization Review Section (S/URS) when taking action which threatens termination of a provider agreement. Refer to **Attachment 29** for additional examples.

The (RMHA) staff must also involve the Regional Deputy Attorney General (DAG) in all actions that set a condition of compliance on a provider for continuing the provider agreement. Written correspondence from the Department should be specific and make clear to the provider what action must be taken to maintain provider status. Information about appeal rights must accompany correspondence that threatens termination of a provider agreement if appropriate action isn't taken by the provider.

Attachment 29: Medicaid S/URS Corrective Action Guidelines (REQUIRED TOOL)

When determining compliance with the current Supplemental Service Agreement, the RMHA will consider at least the following:

1. Are the types of services being provided consistently with those specified in the Supplemental Service Agreement?

2. Are services being provided by qualified individuals with documentation demonstrating clearance for criminal history background?

3. Has the consumer (or legal guardian when appropriate) been given informed consent?

4. Has the provider given each consumer (and/or guardian) information on how to request a fair hearing, how to obtain legal assistance, and the availability and location of consumer protection and advocacy groups?

5. Is there documentation that consumers were advised that they may contact the RMHA to identify alternative providers and/or discuss their dissatisfaction regarding services they are receiving?

6. Provide the RMHA with quarterly listings of all eligible recipients being served; and

7. Provide the RMHA with quarterly listings of all employees and their compliance with the required training.

Accuracy of Billing
To ensure billing accuracy, the RMHA will compare Medicaid billings with consumer services records. This comparison will focus on the following:

1. Documented service units match service units billed to Medicaid;

2. Services being provided are preauthorized by the RMHA and are supervised by a physician;

3. Provision of services is occurring in authorized setting; e.g., institutions are unauthorized settings; and

4. Comparison of number of service units billed and the number of service units authorized.

6. RENEWAL OF SUPPLEMENTAL SERVICE AGREEMENT

The Supplemental Service Agreement is renewed annually. During this review, the RMHA meets with the provider, reviews the provider specific and aggregate consumer outcomes and satisfaction measures. Together, the RMHA and the provider agency decide whether to renew, modify or terminate the Agreement. Changes to the Supplemental Service Agreement can be made by adding a Supplemental Service Agreement Addendum or revising the Agreement. As stated above, any plan to not renew a provider agreement must be referred to the regional Deputy Attorney General and to S/URS.